STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLI		COMPLETED
					09/21/2011
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIE	R	l l		
MINIDOO	D DIDGE			ATERS EDGE PARKWAY	
WINDSO	WINDSOR RIDGE			RSONVILLE, IN47130	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
R0000					
			1		
	This visit was fo	or a State Residential	R0000	F000 Submission of this plan o	f
	Licensure Surve	eV		correction does not constitute	
	Zivensure surve	<i>J</i> .		admission or agreement by the	
	C 1.4 C.			provider of the truth of facts all	eged
	-	eptember 19, 20, and 21,		or correction set forth on the	
	2011		1	statement of deficiencies.	
					,
	Facility number	: 004001	1	This plan of correction is prepa	rea
	Provider number	r: 004001	1	and submitted because of	11
	AIM number: N	J/A		requirement under state and fed	ierai
	Tanvi namoci. 19/14			law. Please accept this plan of correction as our credible alleg	ation
				of compliance.	ation
	Survey team:			or compliance.	
	Gloria J. Reisert	t, MSW/TC			
	Dorothy Navetta	a, RN (9/19 and			
	9/20/2011)				
	,				
	Census Bed Typ	يم.			
	Residential: 37				
	Total 37				
	Census Payor Ty	ype:			
	Other: 37				
	Total 37				
	Residential Sam	nle: 07			
		-			
	Supplemental Sa	ampie: 04			
		idential Findings are cited			
	in accordance w	rith 410 IAC 16.2			
	Ouality review o	completed on September			
	23, 2011 by Bev	-			
	25, 2011 by Bev	Taulkiici, KIN			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NREN11

Facility ID:

004001

TITLE

PRINTED: 10/17/2011 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		00	(X3) DATE S COMPL	ETED
			B. WING			09/21/2	011
	PROVIDER OR SUPPLIER		2	700 WA	DDRESS, CITY, STATE, ZIP CODE ATERS EDGE PARKWAY SONVILLE, IN47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	I	D			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			AG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	DATE
0	REGUESTI OTT OT	zee ibz.viii riive ii ii eidii.iireiv,	1	-			2.112
R0121	(f) A health screen employee of a factor The screen shall in using the Mantoux unless a previousl documented. The millimeters of indudate read, and by facility must assur (1) At the time of e (1) month prior to annually thereafte personnel of facility tuberculosis. The must be read prior work. For health contact the test result during the months, the basel should employ the step is negative, a performed one (1) first step. The frequency depend on the risk tuberculosis. (2) All employees reaction to the skin have a chest x-ray laboratory examinal a diagnosis. (3) The facility shall a diagnosis. (3) The facility shall a diagnosis. (4) An employee wactive disease, (sy active tuberculosis to, cough, fever, noss) shall not be publicated.	a shall be required for each elity prior to resident contact. Include a tuberculin skin test, a method (5 TU, PPD), y positive reaction can be result shall be recorded in ration with the date given, whom administered. The ethe following: employment, or within one employment, and at least r, employees and nonpaid ies shall be screened for first tuberculin skin test to the employee starting are workers who have not dependent to the employee starting are workers who have not depative tuberculin skin testing to two-step method. If the first second test should be to three (3) weeks after the uency of repeat testing will a cof infection with the proceding two departments of and other physical and actions in order to complete that includes reports of all the dealth screenings. With symptoms or signs of the complete to the com					
	Based on record	review and interview, the	R012	.1	R121 Personnel The facility	VVIII	09/23/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NREN11

Facility ID:

004001 I

If continuation sheet

Page 2 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 09/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2700 WATERS EDGE PARKWAY WINDSOR RIDGE JEFFERSONVILLE, IN47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE facility failed to ensure tuberculin skin ensure this requirement is met through the following corrective testing was performed and the results measures:1. First and second were recorded prior to the employees step PPD's have been completed starting work for 4 of 10 employees on employees LPN #1, LPN #2, CNA #1, and Laundry Aide #1. whose files were reviewed. (LPN #1 and No positive reactions were noted. #2, CNA [Certified Nursing Assistant] #1, 2. All active employee files have Laundry Aide #1) been audited to ensure the two-step method was utilized, Findings include: when indicated.3. Administrative nursing staff have been re-educated on the infection During a review of the employee files on control policy related to Employee 9/20/2011 at 3:00 p.m., the following was Tuberculosis Screening (see attachment A). The noted: administrative designee will review all newly hired employee 1. LPN #1 was hired on 7/5/2011 into the files to ensure tuberculosis nursing department and began working screening has been completed as outlined in the policy prior to with residents on 7/6/2011. Review of her starting orientation for 4 weeks file indicated she had received her and again within 21 days of first-step PPD [tuberculin skin test] on starting, ensuring any required 7/4/2011, which was read on 7/7/2011 - 1 2nd step PPD's are completed day after she had begun working with timely. After 4 weeks, he/she will audit 10 employee files per month residents. for 2 months, then 10 per quarter to ensure continued compliance 2. Laundry Aide #1 was hired into the (see attachment B).4. The Housekeeping Department on 6/29/2011 results of ongoing audits shall be reported to the administrator on a and began working with the residents on monthly basis as means of quality the same day. Review of her file indicated assurance. The plan of action will she had received her first-step PPD on be adjusted accordingly.5. The 6/30/2011 which was read on 7/3/2011 - 4 above corrective measures will be completed on or before days after she began working with September 23, 2011. residents. 3. LPN #2 was hired on 7/11/2011 into the nursing department and began working

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
			B. WIN		-	09/21/2	011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				ATERS EDGE PARKWAY		
WINDSO	R RIDGE			1	RSONVILLE, IN47130		
					NOONVIELE, IIV+7 100		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		s on the same day.					
	Review of her file indicated she had						
	received her first	-step PPD on 7/11/2011,					
	which was read of	on 7/14/2011 - 3 days					
	after she had beg	un working with the					
	residents.						
	4. CNA #1 was hired on 8/22/2011 into						
	the nursing depart	rtment and began					
	working with the residents on 8/23/2011. Review of her file indicated she had received her first-step PPD on 8/23/2011,						
	which was read on 8/26/2011 - 3 days						
		•					
	ı	un working with the					
	residents.						
	On 0/20/2011 of	4:45 p.m., the Director of					
		• .					
	""	oresented a copy of the					
		policy on "Employee					
		icable Disease". Review					
	1 1	his time included, but					
	was not limited to	o: "Policy: The facility					
	shall prohibit em	ployees with					
	communicable di	isease or infected skin					
		ect contact with residents					
	or their food. Pro						
		All employees will					
	ı ~	osis screening when					
	hired by this faci	IIIy"					
	The Administrate	or and the DoN indicated					
		after checking the					
		he named staff members					
	should not have l	had contact with the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 09/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2700 WATERS EDGE PARKWAY WINDSOR RIDGE JEFFERSONVILLE, IN47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE residents until their first-step PPDs had been read. R0214 (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident 's condition, or more often at the resident 's or facility 's request. A licensed nurse shall evaluate the nursing needs of the resident. R 214 Evaluation The facility Based on record review and interview, the R0214 09/23/2011 will ensure this requirement is facility failed to ensure the Level of met through the following Service/Evaluations were reviewed and/or corrective measures:1. A Level revised semiannually or as changes of Service Assessment/Evaluation has been completed for residents occurred for 5 of 7 residents reviewed for #1, #3 and #5. Residents #40 Level of Service/Evaluations in a sample and #41 have been of 7 residential residents (Residential discharged.2. All residents have Resident #1, 41, 3, 5 and 40) the potential to be affected. Level of Service Assessments/Evaluations were reviewed on all residents to Findings include: ensure each resident's self-care abilities and needs have been identified.3. Licensed nursing 1. Review of the clinical record for staff were re-educated on the Resident # 1 on 9/19/2011 at 12:30 p.m., need to complete a new Level of indicated diagnoses included, but were Service Assessment/Evaluation not limited to, chronic obstructive upon admission, when a change pulmonary disease, congestive heart in condition is noted, and at least semi-annually thereafter (see failure, coronary artery disease, diabetes policy- attachment C). As means mellitus type 2, and renal failure. of Quality assurance, the administrative designee shall Resident # 1 was admitted on 7/12/2010 audit the record of each newly admitted or re-admitted resident and a "Level of Service within 72 hours of admission and Assessment/Evaluation" was completed.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NREN11

Facility ID:

004001 If continuation sheet

Page 5 of 16

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		09/21/2011
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER		2700 W	/ATERS EDGE PARKWAY	
	R RIDGE		JEFFE	RSONVILLE, IN47130	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	, i	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	On 7/15/2011, an			review the 24 hour report for daily, on scheduled work da	
	Service/Evaluation	on had been completed.		verify the completion of or no	
	Documentation v	vas lacking of a		re-complete an evaluation or	
	semi-annual asse	ssment having been		individual needs of the resid	I
	completed in Jan	uary 2011.		(see attachment D).4. The	
	•	-		results of ongoing audits sha	
				reported to the administrator	• • • • • • • • • • • • • • • • • • •
	2 On 9/19/2011	at 1:45 n m the closed		monthly basis as means of cassurance and the plan of a	
	2. On 9/19/2011 at 1:45 p.m., the closed record review of Resident # 41 included diagnoses; but were not limited to,			adjusted accordingly. 5. Th	
				above correction measures	
	_			be completed on or before	
		ure, hypertension (high		September 23, 2011.	
	blood pressure), and gout. The resident				
		residential on 7/22/2009			
		ged to the hospital on			
	7/1/2011				
	The last "Level o	of Coming			
		uation" was completed			
		cumentation was lacking			
	of any further Le				
		ing been completed since			
	that date.				
	3. Review of the	clinical record for			
	Resident #3 on 9	/19/2011 at 1:20 p.m.,			
	indicated the resi	dent was admitted to the			
		10 and had diagnoses			
		but were not limited to:			
	· ·	oporosis, hypertension,			
		k disease, and anemia.			
	acgenerative dist	x aisease, and anomia.			
	On 9/3/2010, the	initial Level of Service			
	Assessment/Eval				
		osequent Level of			
		•			
	Service/Evaluation	on had been completed			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/21/2011	
			B. WING		
	PROVIDER OR SUPPLIEF DR RIDGE	t	2700 W	ADDRESS, CITY, STATE, ZIP CO ATERS EDGE PARKWA' RSONVILLE, IN47130	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION
IAU	on 8/17/2011. Dof any further se	ocumentation was lacking mi-annual evaluations appleted between 9/3/2010	IAU		DATE
	Resident #5 on 9 indicated the res admitted to the f again re-admitte	clinical record for 0/19/2011 at 12:25 p.m., ident was initially facility on 12/1/2008 and d on 9/1/2011 after apression fracture to her			
	Assessment/Eva completed with a completed on 8/2 was lacking of a Assessments/Eva	Level of Service luation had been a subsequent one being 5/2011. Documentation ny Level of Service aluations having been annually between 4/5/2011.			
	2 day stay in the compression frag Review of the nu 9/1/2011 and 9/1 Nursing Summa had a decline in the changes were back brace, requ Activities of dail	e resident returned from a hospital due to a cture of her lumbar spine. It is in the second of the s			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
			B. WINC	} <u> </u>		09/21/2	011
NAME OF	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP CODE		
					ATERS EDGE PARKWAY		
WINDSC	OR RIDGE			JEFFEF	RSONVILLE, IN47130		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	weakness. Documentation was lacking of						
	a new Level of S						
		luation having been					
	completed.						
	-	riew with the Director of					
	1 -	/2011 at 4:45 p.m., she					
		assessment probably					
	should have been	n completed to reflect her					
	current status.						
	5. Review of the	closed clinical record for					
	Resident #40 on	9/19/2011 at 2:25 p.m.,					
	indicated the res	ident had initially been					
	admitted to the f	facility on 7/24/2009 with					
	subsequent re-ac	lmissions from the area					
	psychiatric hosp	itals on 7/7/2011 and					
	7/29/2011.						
	On 9/15/2010, a	Level of Service					
	Assessment/Eva	luation had been					
	completed. Docu	umentation was lacking of					
	1 ^	-annual Level of Service					
	1 *	aluations having been					
	completed.	S					
	On 7/7/2011, the	e resident had signed					
	1	e psychiatric hospital after					
	1	returned to the facility.					
	1 ' '	ne resident again returned					
	1	ter a 14 days stay in the					
	1	ital. Both stays were due					
	to severe behavi	_					
	Documentation	was lacking of a new					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE COMP 09/21/2	LETED	
	PROVIDER OR SUPPLIER		2700 W	ADDRESS, CITY, STATE, ZIP CODE VATERS EDGE PARKWAY RSONVILLE, IN47130	3	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	having been con reflect the currer and level of assist behavioral issue. During an interve 9/20/2011 at 4:4 was unable to lot Service Assessment completed and conthere were gaps on Residents #1, On 9/19/2011 at Administrator profacility's current Individual Residual the policy at this limited to: "Policy facility that the interesident will be admission/readmassessments will More frequent as performed upon at the time of a kin the resident's will address the	iew with the DoN on 5 p.m., she indicated she cate any other Level of ents/Evaluations ould not explain why in between assessments 41, 3, 5, and 40.				

PRINTED: 10/17/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			DING	NSTRUCTION 00	(X3) DATE S COMPL 09/21/2 (ETED
ROVIDER OR SUPPLIER		B. WING	STREET AI	ATERS EDGE PARKWAY		
(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	Р	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
(e) Following complete facility, using approximembers, shall ideservices to be provided services or resident shall be at (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services of and revised as applete resident and fact change. Either the request a service planaresident upon request and dated of the service planaresident upon requested. No identification services provided subsequent to the need for a change (5) If administration provision of reside both, is needed, a involved in identification the services to be Based on record facility failed to plans on a semi-according to the services to be plans on a semi-according to the services to be plans on a semi-according to the services to be plans on a semi-according to the services to be plans on a semi-according to the services to the plans on a semi-according to the services to the plans on a semi-according to the services to the plans on a semi-according to the services to the plans on a semi-according to the services to the plans on a semi-according to the services to the plans on a semi-according to the services to the plans on a semi-according to the services to the plans on a semi-according to the services to the plans on a semi-according to the services to the plans on a semi-according to the services to the plans on a semi-according to the services to the plans of the services to the services to the services to the plans of the services to the	oletion of an evaluation, the opriately trained staff entify and document the vided by the facility, as ffered to the individual ppropriate to the: ffered shall be reviewed propriate and discussed by acility as needs or desires facility or the resident may plan review. on service plan shall be by the resident, and a copy shall be given to the uest. In and documentation of its needed if evaluations initial evaluation indicate no in services. In of medications or the ontial nursing services, or licensed nurse shall be cation and documentation of provided. review and interview, the review/revise the Service annual basis or as	R02		R 217- Evaluation The facility ensure this requirement is more through the following correcti measures:1. The Service plaresident #5 has been reviewed.	et ve an for ed	09/23/2011
residents reviewe	ed for Service plans in a			and revised as indicated. 2. All residents have the potential to be		
	ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIENT REGULATORY OR (e) Following complete facility, using appropriate members, shall ideservices to be provided to the resident shall be at (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services of and revised as applete resident and fact and revised as applete resident and fact and the request a service plant resident upon request and dated of the service plant resident upon request and the resident upon request a service plant resident upon request a service plant resident upon request and the services provided subsequent to the need for a change (5) If administration provision of reside both, is needed, a involved in identification provision of reside both, is needed, a involved in identification provision of reside both, is needed, a involved in identification provision of reside both, is needed, a involved in identification provision of reside both, is needed, a involved in identification provision of reside both, is needed, a involved in identification provision of reside both, is needed, a involved in identification provision of reside both, is needed, a involved in identification provision of reside both, is needed, a involved in identification provision of reside both, is needed, a involved in identification provision of reside both, is needed, a involved in identification provision of reside both, is needed, a involved in identification provision of reside both, is needed, a involved in identification provision of reside both, is needed, a involved in identification provision of reside both, is needed, a involved in identification provision of reside both, is needed, a involved in identification provision of reside both, is needed, a involved in identification provision of reside both, is needed, a involved in identification provision of reside both, is needed, a involved in identification provision of reside both, is needed, a involved in identification provision of reside both, is needed, a involved in identification prov	ROVIDER OR SUPPLIER R RIDGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference;	ROVIDER OR SUPPLIER R RIDGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluations or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to review/revise the Service plans on a semi-annual basis or as changes occurred for 2 of 7 residential	ROVIDER OR SUPPLIER R RIDGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to review/revise the Service plans on a semi-annual basis or as changes occurred for 2 of 7 residential	ROYIDER OR SUPPLIER R RIDGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL. REGULATORY OR LSC IDENTIFYING INFORMATION) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan shall be gipned and dated by the resident, and a copy of the service plan shall be gipned and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to review/revise the Service plans on a semi-annual basis or as changes occurred for 2 of 7 residential residents reviewed sinclicated and revised as indicated; and revised as indicated resident #5 has been reviewed and revised as indicated resident #5 has been review and revised as indicated resident #5 has been review and revised as indicated resident #6 has been reviewed and revised as indicated resident #6 has been reviewed and revised as indicated resident #6 has been reviewed and revised as indicated resident #6 has been reviewed and revised as indicated resident #6 has been reviewed.	ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER RIDGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility as needs or desires change in the review. (3) The agreed upon service plan shall be given to the resident and revised added by the resident, and a copy of the service plan shall be given to the resident por request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. Or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. RO217 R 217- Evaluation The facility will ensure this requirement is met through the following corrective measures: 1. The Service plan for resident #5 has been reviewed and revised as indicated. 2. All

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NREN11 Facility ID:

004001

If continuation sheet

Page 10 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 09/21/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2700 WATERS EDGE PARKWAY WINDSOR RIDGE JEFFERSONVILLE, IN47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE sample of 7 residential residents. affected and all service plans were audited for compliance. (Residential residents #5 and 40) (See attachment D).3. In an effort to ensure ongoing Findings include: compliance, administrative staff have been re-educated on indications of when to complete a new level of care assessment 1. Review of the clinical record for and subsequent service plan (see Resident #5 on 9/19/2011 at 12:25 p.m., also attachment C). As means of indicated the resident was initially quality assurance, the administrative designee shall admitted to the facility on 12/1/2008 and audit the record of each newly again re-admitted on 9/1/2011 after admitted/re-admitted resident with sustaining a compression fracture to her 72 hours of lumbar spine. admission/re-admission and the 24-hour report sheets daily, on scheduled work days, to ensure On 9/16/2010, a Service plan had been the service plan is revised to completed with a subsequent one being accurately reflect resident completed on 8/11/2011. Documentation performance and provision of care by staff indefinitely (see was lacking of any Service plans having attachment D).4. The results of been completed semi-annually between ongoing audits shall be reported 9/16/2010 and 8/11/2011. to the administrator on a monthly basis as a means of quality assurance and the plan of action On 9/1/2011, the resident returned from a adjusted accordingly.5. The 2 day stay in the hospital due to a above corrective measures will be compression fracture of her lumbar spine. completed on or before Review of the nursing notes between September 23, 2011. 9/1/2011 and 9/15/2011 and the 9/2/2011 Nursing Summary, indicated the resident had a decline in her overall status. Among the changes were, the resident now had a back brace, required 1 assist with her Activities of daily Living, was getting Physical Therapy, and had increased weakness. Documentation was lacking of a new Service Plan having been

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING COMPLETE OD/24/2044			ETED		
			B. WING			09/21/2	011
	PROVIDER OR SUPPLIEI PR RIDGE			2700 W	DDRESS, CITY, STATE, ZIP CODE ATERS EDGE PARKWAY RSONVILLE, IN47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	completed.						
	Nursing on 9/20 indicated a new care probably sh completed to ref	lect her current status.					
	indicated the res admitted to the f subsequent re-ac	9/19/2011 at 2:25 p.m., ident had initially been facility on 7/24/2009 with lmissions from the area itals on 7/7/2011 and					
	completed. Doci	Service plan had been umentation was lacking of ice plans having been					
	herself out of the only 2 days and On 7/29/2011, the to the facility after psychiatric hosp to severe behavior Documentation Service plan have both stays to reference on the control of t	was lacking of a new ring been completed after lect the current status of level of assistance needed					

PRINTED: 10/17/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE COMP 09/21/	LETED
	PROVIDER OR SUPPLIER OR RIDGE	2	2700 W	ADDRESS, CITY, STATE, ZIP COD VATERS EDGE PARKWAY RSONVILLE, IN47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	9/20/2011 at 4:4 was unable to lo plans completed why there were a plan reviews for On 9/19/2011 at Administrator produced this policy at this not limited to: "It of an evaluation using the appropridentify and doc provided to the resident of the scope, frequency of the resident of the reviewer appropriate, and	resented a copy of the policy on "Evaluation of ent Needs". Review of stime included, but was PolicyUpon completion rassessment, the facility, wriately trained staff, shall ument the services resident by the facility, in vice plan, as follows: he services offered to the ent shall be appropriate to ency, need and preference.				

004001

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 09/21/2	ETED	
	PROVIDER OR SUPPLIER		•	2700 W	DDRESS, CITY, STATE, ZIP CODE ATERS EDGE PARKWAY RSONVILLE, IN47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	(X5) COMPLETION DATE
R0356	be immediately ad in case of emerge following: (1) The resident 's apartment number date of birth. (2) The resident 's (3) The name and legally authorized (4) The name and resident 's physic (5) The name and family members or contacted in the edeath. (6) Information on (7) A photograph (resident). (8) Copy of advant Based on record facility failed to contained all information on (7) and 2 of (Residents 8 and Files were review residential resident	phone number of the ian of record. Itelephone number of the rother persons to be went of an emergency or any known allergies. If or identification of the ce directives, if available. Itereview and interview, the ensure the emergency file formation required ince and correct apartment of 7 residents! (Residents 1 4 supplemental residents' 9) whose Emergency wed in a sample of 7 ents and 4 supplemental ents [R - Resident]	RO)356	R356-Clinical Records The facility will ensure this requirement is met through t following corrective measure Residents #1, #4, #8, and #8 emergency records have becorrected and reflect the curn hospital preference and loca of the residents.2. All emergiles were audited to ensure necessary information is provided.3. Administrative shave been re-educated on the emergency record-keeping (attachment E).4. As a mean quality assurance, the Administrator shall be respond to assess completion of the emergency file of each newly admitted resident to confirm continued compliance (see attachment F). Should	es: 1. D's en rent tion lency taff le see s of	09/23/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

NREN11 Facility ID:

004001

If continuation sheet

Page 14 of 16

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
			B. WIN	G		09/21/20	011
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TVIVIL OF I	NO VIDER OR SOLI EIER				ATERS EDGE PARKWAY		
WINDSC	R RIDGE			JEFFEF	RSONVILLE, IN47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
IAG	1. Resident #1 woon 7/12/2010. Reface sheet noted to being in Apartmen current apartmen 2. Resident #4 woon 8/7/2011. Reface sheet noted to being in Apartmen current apartmen 3. Resident #8 woon 1/27/2011. Reface sheet had a president was not hospital unless tr	as admitted to the facility eview of the Admission the resident was listed as ent #124 instead of her t - #120. as admitted to the facility view of the Admission the resident was listed as ent #134 instead of his t - #132. as admitted to the facility eview of his Admission note which indicated the to be transferred to the		IAO	non-compliance be noted, re-education and disciplinary action shall be taken as warranted.5. The above corrective measures will be completed on or before September 23, 2011.	,	DAIL
		ency was lacking.					
	on 10/29/2009. If face sheet noted	as admitted to the facility Review of the Admission the resident as being in instead of her current					
	9/20/2011 at 10:3 they had done a coresident face shed records that contains	d the Corporate RN on 30 a.m., they indicated complete audit of the ets and corrected all					

l	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00		E SURVEY PLETED /2011
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2700 WATERS EDGE PARKWAY JEFFERSONVILLE, IN47130			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	the residents.					